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CLINIC PROBLEMS—CLINICAL AND ADMINISTRATIVE—II.*

THE DEFAULTING CHILD

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THE first point to consider in opening this discussion is whether children suffering from venereal disease default sufficiently often to justify a discussion on "The Defaulting Child." My own experience at Great Ormond Street leads me to believe that they do, and I venture to think this discussion will show that this is also the experience of others.

Several years ago I was much concerned about the number of congenitally syphilitic children whose mothers did not bring them regularly for treatment, and I approached the Ministry of Health to find out whether something could not be done to ensure these children receiving more regular and adequate treatment. As a result the Ministry instituted inquiries among the various clinics in London, and the majority of Clinic Medical Officers or Almoners replied that they did not find that children defaulted more than adults. Several admitted, however, that they had few children attending their clinics. My own feeling is that the comparison between the numbers of defaulting children and adults is irrelevant. There should be no question whatever about default where congenital syphilis is concerned—the treatment should be given regularly and continuously according to plan, except of course when it must be interrupted on account of toxic manifestations, intercurrent disease or other unavoidable cause.

The V.D. Clinic at Great Ormond Street differs probably from all the other clinics in London in that its patients are drawn from a very wide area—as far north as Luton and Aylesbury ; east as far as Shoeburyness and Gillingham ; west as far as Reading ; south as far

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as Croydon and Sutton. Such long journeys entail considerable sacrifices on the part of the mother, and if she has other children besides the patient, these journeys are often made with much difficulty. It is quite understandable that if a member of the family—be it the patient or the mother herself or one of her other children—be indisposed, and particularly if the weather happens to be inclement on the day that she should bring the child to the clinic, that she will put off for a week her visit to the hospital, with the result that the child's treatment is interrupted. If the husband should be out of work, she may not have the money available for the journey, though in cases of necessity this is always refunded to her by the Hospital Almoner, who in turn recovers the sums advanced from the Local Authorities concerned. These bodies generally refund the fares without any question, but sometimes they refuse to do so on the ground that the patient could have attended a hospital nearer her home. When this is subsequently put to the mother, however, she generally—nay, almost invariably—refuses to comply, saying that she would rather not go to a local hospital where she may be recognised, and secondly they often add that they would rather come to Great Ormond Street than go to another hospital.

There are various types or degrees of "defaulting child," depending almost entirely upon the mother.

(1) The negligent, the antagonistic and the mentally-weak mothers give rise to the most frequent cases of defaulting child. Even though it has been clearly explained to them, they cannot or will not appreciate the importance of regular treatment for the present and future health and well-being of their child, with the result that they default on the slightest provocation—even during the first course of injections. It is practically impossible to pilot the child of *such* a mother through a regular and adequate course of treatment which may have to extend over two or more years.

(2) Next we have the mother who is more solicitous about her child than the foregoing, and who endeavours to bring it up regularly for treatment. Default may be the result of genuine illness in the home (either the mother herself, or the patient or a sibling, though sometimes it may be the mother's mother or a more remote relative

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who is the cause of the default) ; or bad weather on the clinic day, or the mother may be going to have another baby and unable to attend regularly. On the whole, by hook or by crook, we generally succeed in getting these children to attend fairly well, so that they receive adequate, if not always regular, treatment.

(3) The least serious type of defaulting child is that which has received apparently adequate treatment with the result that one or two negative blood tests have been obtained, but who cannot be made to come for the annual examination and blood test which is so important, especially from a statistical point of view, in determining whether a definite "cure" has been effected. For this purpose patients should be seen annually until they are at least twenty years old.

(4) There is another type of case which not infrequently crops up and is difficult to deal with. It can hardly be called the "defaulting child" because the child has never attended the clinic, but I refer to the case of children in a known syphilitic family, whom one has asked the mother to bring to the clinic for inspection and blood test. And lastly, there is the special case of this group, the infant born after the mother's treatment during pregnancy, whom the mother will not bring up perhaps more than once because the child is apparently healthy.

STEPS TAKEN AT THE GREAT ORMOND STREET HOSPITAL

If a child defaults, a note is made of the fact, and if it does not attend the following week a personal letter is written to the mother, urging again the importance of regular treatment for the child's health and future welfare. Sometimes this has the desired effect, but the type of mother who requires such letters to be sent her is not likely to attend regularly in reply to one letter, and I generally find that I have to keep on sending them reminders after the child has made one or two attendances. If my letter brings no explanation of absence or no attendance during the ensuing fortnight, I try to get them up through the Almoner, who sometimes succeeds through the agency of a Health Visitor, but for some years past I have availed myself of the services of the

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National Society for the Prevention of Cruelty to Children, whose inspectors have helped a great deal in increasing the attendance of children by personally bringing them to hospital for treatment. The N.S.P.C.C. is unable, however, to deal with *all* my cases owing to the large area covered, and the shortage of personnel and ambulances. In flagrant cases of neglect to bring a child for treatment, I threaten the mother with prosecution for cruelty to her child in not bringing it regularly for treatment, but I have never carried this into effect owing to the uncertainty of the legal position.

One realises, however, that a weekly visit to the clinic extending over a period of many months, especially if from a long distance, and as sometimes happens from a small village one or more miles from a railway station, entails great hardship upon a mother. Some years ago I approached Sir Frederick Menzies with a view to getting some form of institutional treatment for congenitally syphilitic children and, as we would expect him to do, he considered the matter sympathetically and induced the L.C.C. to set aside a certain number of beds and cots (eighteen to twenty) in St. Margaret's Hospital, Kentish Town, for these cases. Since the section of St. Margaret's that was available has been taken over for Vulvo-Vaginitis, the Congenital Syphilis unit has been transferred to St. John's Hospital, Wandsworth, and is now rather smaller than it was. Children up to the age of seven or eight years are admitted and treated for their disease as long as this may be considered necessary—twelve months or longer. This is a distinct step forward in the treatment of congenital syphilis, for it ensures the child getting adequate and regular treatment, and careful nursing and attention during the critical period of the disease. Unfortunately, only London children are admitted free; should the child live outside the administrative County of London, the appropriate Local Authority must undertake to defray the expense—at present £1 11s. 6d. per week. In my experience few M.O.H.'s around London have succeeded in persuading their Authorities to incur this expense, even though it is of undoubted benefit to the child's health and welfare, and in the long run probably also to the ratepayers' pockets by the prevention of incurable neuro-syphilis, which adds its quota to the population of institutions for mentally

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and physically defective children, blind schools and prisons.

Now let us inquire what has been done officially to remedy this state of affairs. Although, as I have already mentioned, the Ministry of Health inquiry did not appear to support my contention that many congenitally syphilitic children default, there were certainly a few who agreed with me; among them our much lamented friend, Dr. David Lees and Col. Tytler Burke, of Salford.* I believe it was Col. Burke who, about the year 1932, first approached the British Social Hygiene Council on this matter and emphasised the seriousness of the situation in the City of Salford. The subject was carefully considered by the Medical Advisory Board of the Social Hygiene Council, under the Chairmanship of the late Dr. David Lees, and the Executive Committee of the Council finally decided that an informal Conference should be arranged to which the Ministry of Health and the Home Office should be asked to send representatives. These two bodies, I regret to say, were unable to comply with the request of the British Social Hygiene Council. An informal conference was held, nevertheless, on December 5th, 1932, under the chairmanship of Sir Walter Greaves-Lord, when Medical members of the Council met representatives of the N.S.P.C.C. and as a result of which it was decided to ask for an opportunity to discuss the matter with the Parliamentary Medical Committee with a view to securing their advice and, if possible, their co-operation, before the Minister of Health was formally approached. The Conference was of the opinion that fresh legislation was not required, as the matter under consideration was covered by the Children's Acts of 1908 and 1932. The difficulties which had arisen were mainly administrative and arose from the Secrecy Clauses of the V.D. Regulations, which were held by the authorities to prevent V.D. Medical Officers giving evidence.

The next step was the reception in May, 1933, of a deputation from the British Social Hygiene Council by the Parliamentary Medical Committee which was presided over by Sir Francis Fremantle, who gave the deputation a sympathetic hearing. It was pointed out

* Incidentally I may say that I am not surprised that Colonel Burke has a considerable number of defaulters in his children's clinic, for his routine treatment of these cases extends over a period of not less than five years.

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by the deputation that the removal of the secrecy stipulation in the case of children would be a simple method of enabling cases of neglect of active syphilitic disease to be dealt with under existing legislation. Subsequently, on June 4th, 1934, a deputation from the British Social Hygiene Council headed by its President, Sir Basil Blackett, was received at the Ministry of Health by Sir Arthur Robinson, Sir George Newman and Col. Harrison. Sir George Newman expressed the opinion that the solution should be sought along lines of development of Social Services in connection with V.D. centres, and agreed to confer with Col. Harrison and myself on the best way of bringing this about. The immediate result was the emission from the Ministry of Health of Form 63, in which the Medical Officers of treatment centres were asked to answer a number of questions as to their experiences and measures adopted in the treatment of syphilitic children. I hope Col. Harrison will be able to give us some information as to the replies which have been submitted to the various questions asked, and that the replies will add weight to the request of the British Social Hygiene Council and of others who are equally interested in the welfare of these children, so that eventually something tangible will emerge. It is an obligation which the medical profession and the community at large owes to these children, who are the innocent victims of the shortcomings of their forbears, to see that they get a "square deal" in the early years of their lives by being provided with adequate treatment, which will give them a reasonable chance of securing physical fitness and mental health.

THE MEASURES I SHOULD LIKE TO SEE ADOPTED ARE :

(1) The secrecy condition attaching to the treatment of Venereal Diseases at Clinics under the Public Health (Venereal Diseases) Regulations, 1916, should be eliminated where children are concerned, because it was certainly never contemplated by the framers of the Regulations that the "confidential" clause could possibly operate so detrimentally to the Congenitally Syphilitic child, as in practice it does.

(2) All candidates for marriage should have a blood test taken, or if this is considered impracticable, then a

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blood test should be taken early in pregnancy and treatment instituted if the result is positive. All expectant mothers attending ante-natal clinics should have a blood test taken.

(3) All cases of general paralysis, tabes and other forms of neuro-syphilis should be notified, so that an inquiry could be made as to the condition of health of the partner and children, if any, with their examination and treatment, if such be considered necessary.

(4) The notification to the local M.O.H. and registration of all cases of congenital syphilis, so that the mother may be kept under observation by the Health Visitor or trained social worker and advised as to treatment in any subsequent pregnancy.

(5) A record kept at some central bureau of children born after the mothers' treatment during pregnancy, so that observation could be made from time to time by the Medical Officers of Welfare Centres and later by School Doctors.

(6) More extended facilities for the institutional treatment of Congenitally Syphilitic children, such as that provided by the London County Council at St. John's Hospital for London children, should be available in different parts of the country, particularly where the proportion of unmarried mothers is unduly high.

(7) It should be made possible and even obligatory for the Local Authorities to prosecute parents or guardians who fail to bring a child for treatment so long as the Clinic Doctor considers this advisable.

(8) Finally. If it were agreed to notify and register all cases of Congenital Syphilis, then it should not be difficult to keep the patients under skilled observation for a period of years with annual inspection and blood and other investigation, if necessary.

The question of defaulters in the vulvo-vaginitis clinic is, in my experience, not a serious one. In our clinic at Great Ormond Street, where we have a small number of beds for the in-patient treatment of gonococcal infections, the patients are, as a rule, kept in for several weeks after the tests are negative to guard against relapses, and usually they come up regularly for periodic tests until they are discharged. In case of default personal letters usually bring them back to the clinic, and I have rarely had to resort to other means.